

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 005022	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 01/28/2015
NAME OF PROVIDER OR SUPPLIER UNION HOSPITAL INC		STREET ADDRESS, CITY, STATE, ZIP CODE 1606 N SEVENTH ST TERRE HAUTE, IN 47804		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	<p>INITIAL COMMENTS</p> <p>This survey was for the investigation of one State complaint.</p> <p>Complaint number: IN00147420 Unsubstantiated; lack of sufficient evidence</p> <p>Date of Survey: 1/28/2015</p> <p>Facility number: 005022</p> <p>Surveyor: Nancy Otten, RN Public Health Nurse Surveyor</p> <p>Union Hospital is in compliance with 410 IAC 15-1.5-2, Infection Control, 410 IAC 15-1.5-5, Medical Staff and 410 IAC 15-1.5-6, Nursing Services, Hospital Licensure Rules.</p> <p>QA: cloughlin 02/24/15</p>	S 000		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE